CALIFORNIA
HOSPITAL
ASSOCIATION

*Providing Leadership in*
*Health Policy and Advocacy*

May 21, 2007

J. Keith Berger
Executive Director
California Medical Assistance Commission
770 L Street, Ste. 1000
Sacramento, CA 95814

Re: Distressed Hospital Funding Program

Dear Mr. Berger:

Thank you for your letter of May 2, 2007, inviting the California Hospital Association (CHA) to submit comments to assist the California Medical Assistance Commission (CMAC) in its review of the focus and process for the upcoming 2006-2007 Fund negotiations. CHA, on behalf of California's hospitals, is pleased to provide our thoughts and perspectives that may be considered by CMAC during the 2006-2007 negotiations for the Distressed Hospital Funding (DHF) Program.

CHA supports the eligibility criteria for DHF participation in which hospitals must serve a substantial volume of Medi-Cal patients, are a critical component of the Medi-Cal provider network and demonstrate a significant financial hardship. Many California hospitals meet these requirements, with recent Office of Statewide Health Planning and Development (OSHPD) data reflecting an aggregate $1.8 billion in uncompensated losses for hospitals participating in the Medi-Cal program. This shortfall confirms the broader concern of insufficient contract rates that cannot be remedied by the distribution of Distressed Hospital Funds.

CHA encourages CMAC to access DHF in conjunction with addressing the underlying deficiency in Medi-Cal payments through hospital rate negotiations. Last year, CMAC received over 80 proposals from distressed hospitals requesting more than $140 million in funding, which reiterates the chronic under-funding to Medi-Cal hospitals. CHA believes that in order to maximize the effectiveness of the amount of available DHF, CMAC should focus on a limited number of hospitals that are demonstrating the highest need for Distressed Hospital Funding.

We appreciate the opportunity to provide our comments to you and the Commission. We hope the comments will provide CMAC with good information to define the focus and process for the 2006-2007 Fund negotiations. Please call me if you have any questions or need more information.

Sincerely,

C. Duane Dauner
President

AM/CDD:nr

CALIFORNIA
children's
HOSPITAL
ASSOCIATION

1215 K Street
Suite 1930
Sacramento, CA 95814
916-552-7111
916-552-7119 (fax)

May 18, 2007

J. Keith Berger, Executive Director
California Medical Assistance Commission
770 L Street, Suite 1000
Sacramento, CA 95814

SUBJECT: Distressed Hospital Funding Program

Dear Mr. Berger:

The California Children's Hospital Association (CCHA) is pleased to provide comments on the 2006-07 Distressed Hospital Funding (DHF) Program and fund negotiations.

A significant problem for hospitals is inadequate payments from the state for providing care to Medi-Cal patients. This chronic underfunding of reimbursement to hospitals for taking care of Medi-Cal beneficiaries can be resolved only when sufficient state appropriations, matched by federal funds, are available to pay hospitals for the costs incurred when treating these patients. The funds available in the DHF, however, are minor when compared to the underlying deficiency in Medi-Cal payments to hospitals. As such, we are pleased to see that the Administration plans to address the issue of insufficient Medi-Cal provider reimbursement as part of the current health care reform proposal.

Deficient Medi-Cal reimbursement impacts all hospitals that take care of the Medi-Cal population, but has a greater impact on safety net hospitals, such as children's hospitals, because of the high volume of Medi-Cal patients treated at these facilities. For children's hospitals, on average, Medi-Cal is the payer for 50 percent of all patients and over 70 percent at Los Angeles and Central California.

While we acknowledge that there are limited funds made available through the DHF, children's hospitals urge CMAC to consider the critical role (and the resulting financial losses) safety net

providers play in taking care of a large volume of Medi-Cal patients when making decisions on the distribution of this fund.

As children's hospitals and other safety-net providers are providing more care in outpatient settings, and since the Medi-Cal outpatient fee schedule reimburses hospitals at less than half the costs incurred, we believe it is critical that the funds be available to address both inpatient and outpatient shortfalls.

Regarding the substantial volume requirement included in the DHF, children's hospitals recommend this be defined as a hospital's proportion of Medi-Cal inpatient days, its proportion of Medi-Cal outpatient visits, or its Medi-Cal ER visits. We believe it is important to look at both traditional and managed care days/visits when calculating volume.

Children's hospitals recommend looking at a hospital's market share of Medi-Cal inpatient days or its volume of Medi-Cal ER visits in defining the 'critical component' provision of the DHF. We would recommend creating two categories of market share within each Health Facility Planning Area (HFPA): adult market share and pediatric market share. For a hospital to be considered a 'critical component', it would have to be one of the top two providers of Medi-Cal adult and/or pediatric services in their HFPA. A hospital could also meet the 'critical component' criteria by generating Medi-Cal ER visits greater than the statewide median.

Children's hospitals recommend that the Commission consider a variety of factors in determining if a particular hospital's inpatient or outpatient program/service is experiencing a financial hardship such as (a) access to services being at risk, (b) number of Medi-Cal patients served, (c) hospital payer mix, (d) acuity/severity of illness of patients served at the hospital.

Children's hospitals thank you for your consideration of our Distressed Hospital Fund comments. We recognize the challenges you are facing with the limited funds available coupled with hospitals' increasing costs and Medi-Cal utilization . We stand ready to work with you throughout this process.

Sincerely,

Diana S. Dooley

Diana S. Dooley
President & CEO

cc: CCHA Board of Directors

Daughters of Charity
Health System

May 18, 2007

Mr. Keith Berger
Executive Director
California Medical Assistance Commission
770 L Street, Suite 1000
Sacramento, CA 95814

By Fax: 916-324-5597

Re: Distressed Hospital Funding Program

Dear Mr. Berger:

On behalf of Daughters of Charity Health System (DCHS), I am pleased to respond to your invitation to provide comments on the focus of the 2007 Distressed Hospital Fund negotiations. I am responding on behalf of DCHS and two of our local health ministries that have submitted applications under the Fund, St. Vincent Medical Center and Seton Medical Center.

Our hospitals provide the full range of services including virtually all acute care services, long term care and community health services. Our large hospitals (St. Vincent, Seton, St. Francis Medical Center and O'Connor Hospital) serve Medi-Cal patients and each participates in CMAC's Selective Provider Contracting Program.

DCHS' mission is to provide quality, compassionate, holistic health care to all who require it. No ill or injured person is ever turned away from any of our hospitals because of an inability to pay. *We believe this should also be the foundation of CMAC's Distressed Hospital Fund program.* The Fund is critically important in helping us fulfill our mission of service to the sick and the poor.

The Commission has the difficult task of determining the most effective allocation of very limited distressed hospital dollars in order to have the greatest impact on meeting the needs of Medi-Cal patients. In doing so, it is important to assess the services that are reasonably accessible to patients in their communities and what is necessary to sustain and to expand that availability. The needs of individual hospitals are best reviewed in the context of the role they play as part of the Medi-Cal delivery system in the communities they serve. What is required in that community to provide necessary expansion of services?

If patient access to care, including the complete spectrum of services required to provide quality care, is jeopardized, the Medi-Cal program does not work. Community access is key. If services to Medi-Cal patients become limited in a community by hospital closure, downsizing and/or the discontinuation of Medi-Cal or specific Medi-Cal services, it becomes geographically difficult for these patients to access care. The ability of the Medi-Cal health care delivery system to operate depends on the remaining "core" Medi-Cal providers in that community. The goals of the Medi-Cal program cannot be realized without these core hospitals taking on additional volume.

Medi-Cal is often the cause of financial distress on the part of these core providers, and, at a time when their role in the community is more important than ever, the financial burden that comes with increased service to Medi-Cal patients becomes more severe. Ensuring the ability of these hospitals to continue service to Medi-Cal patients is exactly why the Distressed Hospital Fund program was created.

In assessing the needs of communities, the Commission should also consider other sources of public and/or private funds being used to support care to the poor, and how Distressed Hospital Funds can be used to leverage such funds and stabilize the Medi-Cal health care delivery system in these communities.

Accordingly, we recommend the Commission apply the statutory requirements in the context of community needs. The following are our specific recommendations:

1. Number or Percentage of Medi-Cal Patients

In implementing the requirement that a hospital "serve a substantial volume of Medi-Cal patients" the Commission should give special consideration to the fact that access to medical care, including specialized care, is vital to the Medi-Cal program, regardless of whether the hospital serves a substantial volume. Benchmark percentages fail to take into account the nature and breadth of services provided to Medi-Cal patients by each hospital, the ability of other hospitals in the geographic service area to maintain their levels of service to Medi-Cal patients, and whether it is the mission of each hospital to serve Medi-Cal patients. These factors must be considered in determining the significance of the hospital's role in serving the Medi-Cal population. This is especially important because in assessing the health care available to Medi-Cal patients in a particular area, the specialized services taken together comprise the delivery system in that area.

2. Necessity of The Hospital's Role in The Medi-Cal Health Care Delivery System

The most important statutory requirement is that a hospital be a "critical component of the Medi-Cal program's health care delivery system." The needs of communities with respect to Medi-Cal services are paramount. The nature of services a hospital provides to Medi-Cal patients in a community and the ability of those patients to receive those services elsewhere should be the Commission's prime consideration.

The Commission is aware that some Medi-Cal providers are de-emphasizing certain types of services to Medi-Cal patients. Others have exited Medi-Cal altogether. When Medi-Cal services are limited within a particular community, the Medi-Cal delivery system becomes increasingly reliant on "core" providers. These core hospitals take on an additional volume of Medi-Cal patients and, in many cases, are the sole Medi-Cal provider within a community or the sole provider of specific services. This is especially important in areas such as Los Angeles where the downsizing of Martin Luther King Medical Center has required private hospitals to play such a critical role.

3. Financial Hardship: Hospitals' Ability to Sustain Current Level of Services

The health and well-being of communities is dependent upon the ability of core Medi-Cal providers to retain the financial strength necessary to continue operations. Distribution of Distressed Hospital Funds to core providers that are losing significant sums of money and forced to lay off employees or face other serious financial issues is critical. Ensuring the ability of a core provider to continue operations in a community where service to the Medi-Cal population is limited appears exactly why the Fund was created.

4. Changed Circumstances

The Commission should also consider changed circumstances. Many private hospitals have closed or discontinued accepting Medi-Cal patients, and are directing those patients to other hospitals in the community. The drastic downsizing and elimination of critical services at Martin Luther King Medical Center has prompted neighboring hospitals to mitigate the impact on indigent patients. The remaining private hospitals willing to serve the poor often have insufficient capacity and time to prepare to serve the additional patients, and must take steps to do so which place the hospital at financial risk.

While the volume of patients may not constitute a major increase, the nature of the services provided; the demographics of the patients being diverted (disabled, cultural/ethnic issues, etc.) and the mere fact the hospital's mission requires it to serve those patients, should be a strong consideration in the distribution of the Distressed Hospital Funds.

The funding should be focused on those hospitals that have made the commitment to the Medi-Cal program and will continue that commitment despite the extraordinarily difficult circumstances facing them. The funds should not be used to prop up institutions that may well walk away from Medi-Cal due to the fiscal problems the population brings with it.

DCHS has a long standing commitment to the sick poor in California, and that commitment will never waiver. We look forward to working with the Commission and its staff to maximize the use of the Distressed Hospital funds.

Sincerely,

Conway Collis

Conway Collis
Vice President of Advocacy
Chief Government Affairs Officer

cc: Robert Issai, President & CEO, Daughters of Charity Health System
Cathy Fickes, President & CEO, St. Vincent Medical Center
Bernadette Smith. President & CEO, Seton Medical Center

Good
Samaritan
Hospital

Via Overnight Mail

May 17, 2006



Mr. Keith Berger
Executive Director
California Medical Assistance Commission
770 L Street, Suite 1000
Sacramento, CA 95814

Re: Process for Distributing the Distressed Hospital Fund

Dear Mr. Berger and Honorable CMAC Commissioners:

Good Samaritan Hospital appreciates the opportunity to share its opinion regarding how CMAC should distribute the Distressed Hospital Fund that was created by Senate Bill 1100, and codified at Welfare & Institutions Code §§ 14166.20 and 14166.23. Good Samaritan advocates a data driven decision-making process for the distressed hospital fund and offers a five point plan:

1. Limit the number of hospitals that receive the funds so the hospitals that are granted distressed hospital funds will receive meaningful amounts.

2. In applying the law's criteria with respect to significant financial losses and provision of critical services, generally limit the distributions to hospitals that:
   a. Have sustained operating losses in the most recent fiscal year, plus in the previous three years and
   b. Offer at a minimum emergency services (basic or higher) and obstetrics, plus give preference to those Hospitals that also offer NICU and other tertiary care services.

3. Allocate the limited distressed hospital funds first to hospitals like Good Samaritan that do not have access to the disproportionate share funds that can help cover the losses.

4. Avoid distributions to governmental hospitals that are reimbursed using the certified public expenditures (especially since such distributions are not, we understand, eligible for federal funding participation (FFP), which would reduce the amounts available in the distressed hospital fund). Priority should be given to distributions that are eligible for federal matching funds.

5. Allow the fund to supplement payments only to the point of covering the costs for providing care for Medi-Cal patients (and take into account not only Medi-Cal Payments under the SPCP, but also disproportionate share funds distributed pursuant to SB 1100 when calculating what a hospital receives for Medi-Cal patients).

When assessing the merits of this proposal, it may be helpful to recall the origin of the distressed hospital fund. In 2004 and before, Good Samaritan Hospital in Los Angeles was experiencing a financial crisis, incurring losses that were increasing year after year despite the attention the Hospital was giving to maximizing efficiency and reducing costs. In the worst year, the Hospital lost over $22 million. When the Hospital looked at its revenue options, it found that other inner city hospitals that were treating a large number of Medi-Cal and indigent patients were surviving financially because they were receiving substantial funding from the disproportionate share program in addition to the base rate from the SPCP contract. Good Samaritan considered whether it could increase the number of Medi-Cal patients so it could exceed the DSH threshold and qualify for DSH status. As it turns out, this was not a viable option. The Hospital has a large number of patients who received care in its cardiology and cardiac surgery programs, orthopedic surgery programs, and other renowned tertiary care programs, which increased the total number of patients served by the Hospitals. The Hospital determined it could not reach the required percentage threshold of Medi-Cal patients unless it eliminated many of its tertiary care services, which was not the best choice for the Hospital or its patients.

The Hospital was encouraged by CMAC commissioners and others to seek legislation that would address the inequities of the DSH program, but was warned it would be an uphill battle against strongly entrenched DSH interests. The Hospital pursued the legislative relief and was very pleased when SB 1100 provided for the establishment of the distressed hospital fund – which provides a small amount of money (relatively speaking) that would be available to non-DSH hospitals that are critical to the Medi-Cal patients, and care for a high volume of Medi-Cal patients, but face severe financial challenges.

The fund is not large. As CMAC pointed out in its 2006 Annual report, in the first year, it had only $13.5 million plus FFP matching funds to distribute. Although this year the amount should be nearly double that (with the addition of another $23.5 million when the final federal approvals have been secured so the funding from the stabilization fund can be released and added to the prior supplemental funds of $13.5 million plus FFP), it still does not approach the $140 million in requests received last year. But while the amount in the fund is small when compared with the total Medi-Cal spending, it is essential for hospitals like Good Samaritan which are not DSH hospitals yet are key providers in the Medi-Cal program because they provide a very high volume of services for Medi-Cal patients, plus offer critical access services such as emergency rooms, obstetrics, and neonatal intensive care. It is appropriate to relieve the financial distress these hospitals face, especially when the distress is measured by multiple years of continuing losses.

We urge you to adopt the five point plan as your process for distributing these important funds, to help stabilize the hospitals that truly need help from the distressed hospital fund.

Sincerely,

Andrew B. Leeka
President & CEO

ABL
andy/berger5-16-07

CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

May 18, 2007

Mr. Keith Berger
Executive Director
California Medical Assistance Commission
770 L Street, Suite 1000
Sacramento, Ca 95814

Dear Mr. Berger:

On behalf of California's public hospitals and health systems, I am writing to share our thoughts on the Distressed Hospital Fund created by SB 1100. We appreciate the opportunity to comment on how those funds could be used to help stabilize the state's hospital safety net and help ensure continued access to care for low-income Californians.

Public hospitals are the cornerstone of California's health care system. Our 21 public hospitals make up just 6 percent of all hospitals, but provide more than half the hospital care to the state's 6.5 million uninsured, operate 60 percent of the top-level trauma centers and train half the state's doctors.

Now that we are in Year Two of the Medi-Cal hospital financing waiver, we have a clearer picture of public hospitals' financial health. While the structure of the waiver did include new money for public hospitals in both Year One and in Year Two, public hospitals continue to operate under severe financial strain and face ongoing challenges in serving the millions of low income, Medi-Cal and uninsured patients who rely on them for health care.

CAPH shares the goal of the Distressed Hospital Fund in preventing significant disruptions in health care delivery to Medi-Cal beneficiaries. As the Commission re-examines its process for the 2006-2007 negotiations, we ask you to consider four factors in the distribution methodology for the Distressed Hospital Fund.

First, public hospitals that meet the criteria for being a "distressed" hospital should have access to these funds despite the fact that the funds distributed to public hospitals cannot be matched with federal dollars. Public hospitals are being disadvantaged in Distressed Hospital Fund negotiations because funds distributed to public hospitals cannot be matched with federal dollars. We are concerned that CMAC may be using this lack of matchable funds as a reason for excluding them from receiving Distressed Hospital Funds.

SB1100 specifically allows Distressed Hospital fund dollars to be available to all hospitals, including public hospitals. CMAC should not disadvantage public hospitals because of this issue.

Second, public and private disproportionate share hospitals should be given priority for Distressed Hospital Funds. Public hospitals form the core of the safety net in the state and in local communities. The existence of financially distressed public hospitals threatens access to care for the patients and communities they serve and the private hospitals that surround them. These funds could make a real difference to prevent severe service reductions that some public hospitals are contemplating. CAPH notes that the legislative intent of the Distressed Hospital Fund is to ensure that resources are available to address emergency situations where a hospital's financial hardship causes significant disruption to the Medi-Cal health care delivery system, which also serves the uninsured. The resources used for this purpose are funded from two sources: (1) by previously unused Intergovernmental Transfers, or IGTs, made by counties or county hospitals and by the University of California; and (2) from the stabilization funds made available to DSH hospitals through the Safety Net Care Pool (SNCP). Thus, first priority for distribution should be given to public and private DSH hospitals, as they represent the main sources of funding. CAPH is concerned that no public hospitals received Distressed Hospital Funds in the 2005-2006 year. We want to express our strong hope that CMAC will acknowledge the financial distress that many of our members are facing in awarding funds during the 2006-2007 year.

Third, CAPH continues to believe that, in order to receive Distressed Hospital Funds, non-DSH must show that their financial hardship is related to care for the uninsured as well as care for Medi-Cal beneficiaries. CMAC should give preference to distressed hospitals that provide charity care in line with the national average of 5 percent. (Source: PricewaterhouseCoopers 2005 Charity Care Survey) Hospitals that do not qualify for DSH status may face financial hardship due to low Medi-Cal payment rates. However, that fact alone should not be sufficient to access these funds. In the context of the hospital financing waiver, an important public policy objective is to ensure that care is provided to the indigent and uninsured, as well as Medi-Cal beneficiaries. Providing such charity care should be a contributing factor to the hospital's financial hardship. The national average of hospital charity care is a reasonable benchmark for making such a determination.

Fourth, upon receiving funds from this program, hospitals should be held to a high level of public accountability. CAPH recommends that receiving hospitals be required to publicly promote their charity care, disclose their charity care policies and report the amount of charity care they provide for a period of three years.

We believe that these four factors will focus the available funding on the neediest providers that have demonstrated a commitment to their community mission. The negotiation and payment process should follow that used for SB 1255 payments with vigorous review of the data that supports the financial distress. Absent imminent closure threats, the process should occur toward the end of the fiscal year to assure that the limited funds are distributed in the most appropriate manner consistent with the factors discussed above.

Again, thank you for the opportunity to comment. We look forward to discussing these issues further at the hearing on May 24.

Sincerely,

Melissa Stafford Jones
President and CEO

Downey Regional Medical Center

11500 Brookshire Avenue
P.O. Box 7010
Downey, CA 90241-7010
Tel. 562-904-5000
Fax 562-904-5309
www.drmci.org

Writer's Direct Dial
(562)904-5187

May 16, 2007



Ms. Cathie Bennett Warner, Chair
California Medical Assistance Commission
770 L Street, Suite 1000
Sacramento, CA 95814

Re: Public Comment for Distressed Hospital Funds

Dear Ms. Warner:

Downey Regional Medical Center appreciates this opportunity to comment upon the process for the Distressed Hospital Fund. Last year, the Commission took legislative guidance and crafted a policy that was consistent with the Legislature's intent to ensure the survival of key hospital infrastructure in the State of California. It did so with the full knowledge of the disproportionate share and other programs that greatly benefit hospitals qualifying under those other programs.

The Legislature saw the need to provide additional funds for a small group of hospitals that were in financial difficulties because they were providing essential safety net services, but were not otherwise adequately funded because they didn't qualify for existing programs or support. We believe that the hospitals in this category were given a fair chance to present their cases last year, and we understand that the Commission made awards to a few hospitals state-wide that could benefit from a concentrated award from the Distressed Hospital Fund.

Accordingly, Downey Regional Medical Center urges that the Commission take the same approach for the process for the Distressed Hospital Fund this year. Furthermore, it should follow a policy of distribution to a limited number of hospitals not qualifying under disproportionate share, that provide key safety net services to underserved populations. The Commission should make substantial awards that would enable the hospitals to continue to provide the needed services.

Sincerely,

Robert E. Fuller
Executive Vice President and
Chief Operating Officer

Cc: Executive Director, J. Keith Berger